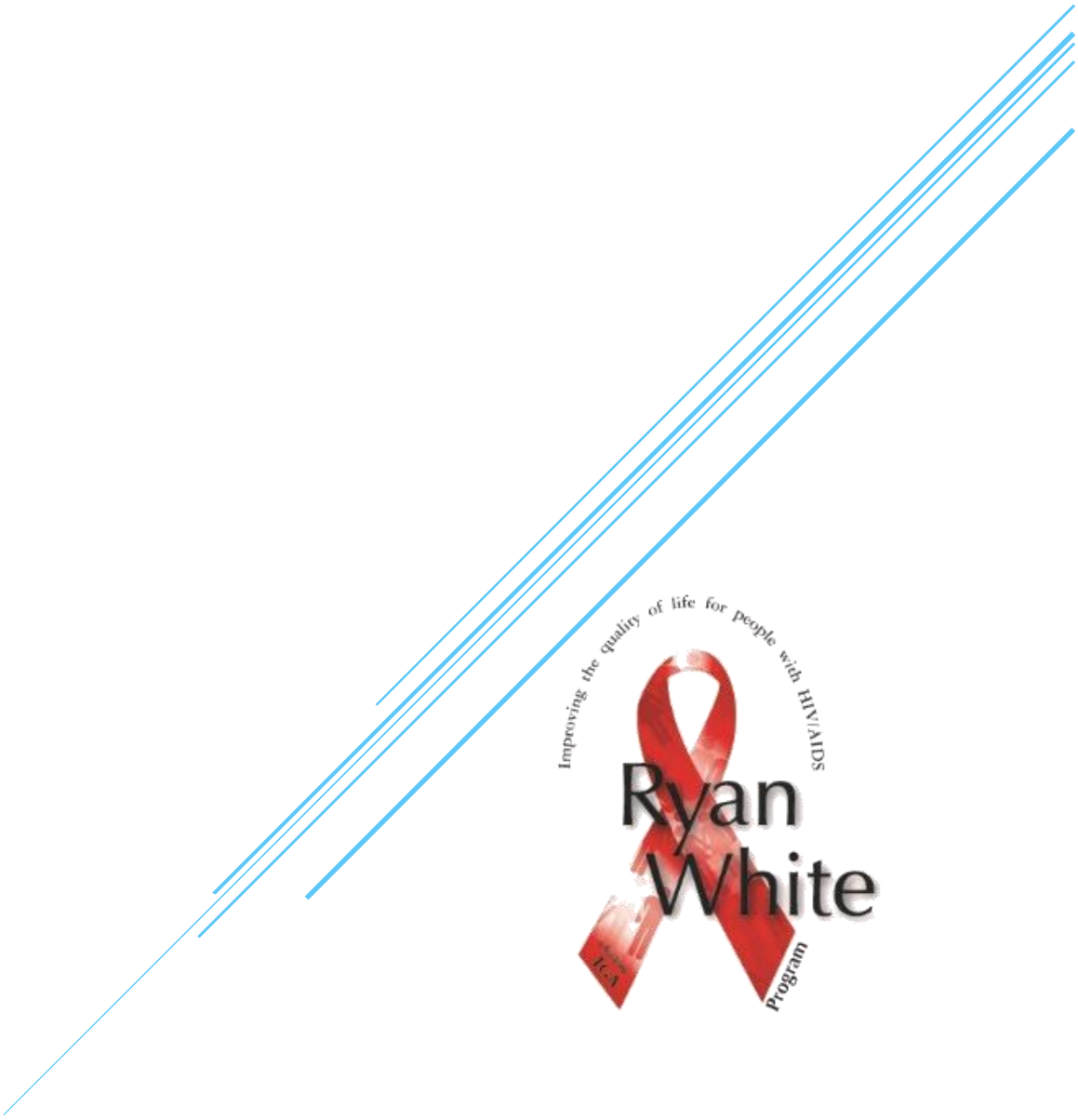
Service Standards

Ryan White Part A Program
Charlotte Transitional Grant Area



FY 2020-2021

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Introduction

Ryan White Part A

Mecklenburg County is a recipient of Ryan White Part A Program funding. RWHAP is the largest federal program dedicated to improving the quality and availability of care for low-income, uninsured, and underinsured individuals living with HIV. The program is administered by the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). HRSA estimates that RWHAP provides core medical and support services to over a half million people a year; reaching over 50% of all persons diagnosed with HIV in the US!

As a RWHAP Recipient, Mecklenburg County oversees and administers the RWHAP in the Charlotte Transitional Grant Area (TGA), a six-county area which includes Anson, Cabarrus, Gaston, Mecklenburg, Union (NC), and York County, (SC).

Goals of Ryan White Part A

The goals and activities of the Charlotte TGA align with the National HIV/AIDS Strategy (NHAS) and with HRSA-HIV/AIDS Bureau requirements and priorities. The goals of the program are to:

1. Identify and link to medical care people who were previously unaware of their HIV status
2. Re-engage people living with HIV who are not currently engaged in medical care
3. Support people living with HIV in maintaining ongoing HIV medical care
4. Provide resources to address social determinants of health and reduce HIV-related health disparities
5. Assist people living with HIV to achieve positive health outcomes, including HIV viral load suppression

To accomplish these goals, Mecklenburg County provides funding for core medical services and essential support services. No less than 75% of Ryan White funds are utilized for core medical service categories, which includes services that directly focus on medical activities. No more than 25% of Ryan White funds are used for support service categories, defined as wrap-around services that address psychosocial barriers to medical care adherence.

Application of Service Standards

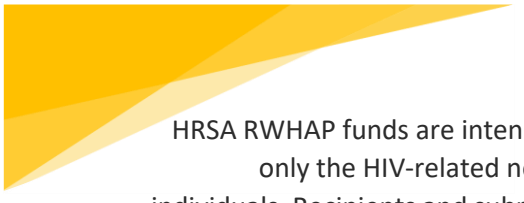
This document outlines the Service Standards for all Ryan White Part A funded programs in the TGA. The purpose of these standards is to ensure the quality and consistency of Ryan White core medical and support services throughout the TGA, ensuring that all consumers of services receive the same quality of service regardless of where or by whom the service is provided. Standards are used as contract requirements, in program monitoring, and in Quality Management.

These standards apply to all agencies that are funded to provide Part A and/or Minority AIDS Initiative (MAI) services through the Charlotte TGA's Ryan White Part A Program. These standards should be used in combination with the HRSA/HAB Universal Service Standards that apply to any agency or provider funded to provide any Ryan White Part A and/or MAI service.

Standards Development Process

These standards were developed in partnership with the TGA's Ryan White Planning Body, Ryan White Program Staff, and Quality Management Team. Standards are based on a review of the existing standards; and extensive research on HRSA/HAB's Universal Service Standards, State requirements of North and South Carolina, medical standards set forth by the US DHHS, and evidence-based approaches.

This is a living document. Service Standards will improve as consumer needs arise, best practices develop, and HRSA/HAB guidance changes.



HRSA RWHAP funds are intended to support only the HIV-related needs of eligible individuals. Recipients and subrecipients must be able to make an explicit connection between any service supported with HRSA RWHAP funds and the intended client's HIV care and treatment, or care-giving relationship to a person living with HIV (PLWH).

HIV/AIDS Bureau Policy 16-02

General Standards for all Services

General Standards apply to all HRSA RWHAP Part A funded services and providers.

Intake & Eligibility	**Measure**
Eligibility assessment is completed within 30 days of intake and includes: 1. Proof of HIV status 2. Proof of income no greater than 300% of the Federal Poverty Level (FPL) 3. Proof of residence in the TGA 4. Copy of health insurance, Medicaid, and/or Medicare cards	Documentation in consumer files Dental/Vision providers do not need to collect this information, as the referring agency has this information.
Services are provided to all Ryan White Part A qualified consumers without discrimination based on: HIV status, race, ethnicity, creed, age, sex, gender identity or expression, marital or parental status, sexual orientation, religion, physical/mental disability, immigrant status, or any other basis prohibited by law.	Policies and Procedures Consumer Satisfaction Surveys
The intake process begins within 10 working days of the consumer's referral to the agency and is flexible to meet the needs of consumers with disabilities and health conditions. In addition to office visits, the agency offers alternatives such as conducting the intake by mail or home visits.	Policies and Procedures Documentation in consumer files
Agency accepts referrals from sources considered to be points of entry into the continuum of care across the Charlotte Transitional Grant Area.	MOUs/MOAs with partner agencies; Documentation of referrals/follow-up
Key Services Components and Activities	**Measure**
Agency institutes Policies and Procedures for cost sharing (enrollment fees, premiums, deductibles, copayments, coinsurance, sliding fee discount) and an annual cap on these charges. Agency does not charge fees to Ryan White eligible consumers whose gross income level (GIL) is ≤100% of the Federal Poverty Line (FPL). Consumers whose GIL is 101-300% may be charged annual aggregate fees consistent with the following legislative mandate: 1. 101-200% of FPL: 5% or less of GIL 2. 201-300% of FPL: 7% or less of GIL 3. >300% of FPL: 10% or less of GIL In addition, agency implements the following: 1. Six-month evaluation of consumers to establish individual fees and cap 2. Tracking of charges and documentation of fees 3. A process for alerting the billing system when the cap is reached so consumer will not be charged for the rest of the fiscal year 4. All consumers accessing services are provided with a clear description of their sliding fee charges at intake and annually during recertification	Policies and Procedures Review of system for tracking consumer charges and payments Documentation of charges and payments in consumer files Sliding fee application consistent with Federal guidelines
Agency provides broad-based dissemination of information regarding the availability of services and eligibility requirements.	File documenting promotion activities, copies of promotional materials
Staff are present to answer incoming calls during agency's normal operating hours. If the office is closed during normal operating hours, staff notify consumers at least 2 weeks before the scheduled closing.	Policies and Procedures
Staff return emails/voicemails from consumers within 24 business hours.	Policies and Procedures
Agency demonstrates commitment to quality and performance improvement.	Policies and Procedures / QM Plan; Action plan based on consumer satisfaction surveys
Agency offers services at non-traditional hours and in non-traditional settings, including satellite offices and telehealth to meet the needs of consumers with geographic, transportation, and/or scheduling barriers.	Policies and Procedures
Agency practices trauma-informed care for all direct services provided.	Policies and Procedures; Staff training documented in staff files

Personnel Qualifications	Measure
Staff receive annual training for at least 12 hours per year (full-time staff) or 6 hours per year (part-time staff) in one or more of the following topics: 1. HIV, STD, and Hepatitis C updates 2. Racial equity and/or cultural sensitivity 3. Transgender / non-binary gender sensitivity 4. Social determinants of health 5. Trauma-informed care 6. Community resources, including public transportation 7. Consumer retention 8. Mental Health First Aid 9. Mental health, substance use, and/or intimate partner violence 10. Motivational Interviewing 11. HIV Testing, Counseling, & Referral sponsored by the NC/SC HIV/STD Prevention and Care Section 12. Confidentiality and HIPAA (especially new staff) 13. Universal precautions (especially new staff)	Training certificates in staff files
Agency performs annual staff performance evaluations for all staff providing Part A and/or MAI services.	Completed annual performance evaluation in staff files, signed and dated by staff and supervisor
Staff and volunteers of an agency do not have sexual/intimate relationships with persons who are currently receiving services from that agency.	Policies & Procedures Staff signature on Code of Conduct form in personnel files
Transition & Discharge	**Measure**
Consumers may be terminated from services because of reassessment or any form of consumer ineligibility. Consumers or providers may initiate termination. Conditions resulting in a consumer's termination may include: 1. Attainment of goals 2. Change in status which results in program ineligibility 3. Consumer desire to terminate services 4. Death 5. Consumer's actions put the agency, staff, or consumers at risk of harm 6. Consumer enters jail and/or cannot be contacted for 90 days Agency must document 3 attempts to contact consumer by more than one method (phone, email, home visit, etc.).	Documentation in consumer files Policies and Procedures
Consumer is provided a written notice before involuntary termination and has at least 30 days to appeal termination.	Documentation in consumer files
If terminated, the consumer is referred to another agency and at least 3 community resources relevant to consumer's needs.	Documentation in consumer files
Case Closure Protocol	**Measure**
A progress note is completed within 3 business days of closure, including: 1. Date and reason for discharge/closure, 2. Summary of all services received by the consumer and the consumer's response to services, 3. Summary of contact made with consumer regarding termination and consumer's response, 4. Referrals made (minimum 3), and/or 5. Instructions given to the individual at discharge (when applicable).	Documentation in consumer files

Consumer Rights & Responsibilities	Measure
Agency annually reviews Consumer Rights & Responsibilities with each consumer in a language and format the consumer understands. Agency provides consumer with written copy of their rights & responsibilities, including: 1. Informed consent 2. Confidentiality 3. Grievance procedures 4. Duty to warn or report certain behaviors 5. Scope of service 6. Criteria for termination of services	Documentation in consumer files
All consent forms comply with state and federal laws, are signed by an individual legally able to give consent and include the Consent for Services form and a consent for release/exchange of information for every individual/agency to whom identifying information is disclosed. Consent forms expire after one year of the consumer's signing date.	Policies and Procedures Signed and dated consent forms in consumer files
Consumers are not wait-listed, nor are services postponed or denied because of funding. Agency notifies the Ryan White Program Office when funds for a service are low or exhausted. If services cannot be provided timely, the agency links the consumer to another agency.	Policies and Procedures Documentation of agency communication with RW Program
Consumers must notify staff of any change in eligibility status or if any problems are found with the services provided.	Documentation in consumer files
Agency has Policies and Procedures in plan to ensure that PLWH are not denied services due to pre-existing health conditions. A file is maintained on all consumers who are refused services and the reason for refusal.	Policies and Procedures; File on consumers have been refused services
Agency demonstrates a commitment to assisting consumers with special needs.	Agency compliance with the Americans with Disabilities Act
Grievance Process	
Agency annually reviews its Grievance Policy with each consumer in a language and format understandable to the consumer; a written copy of which is provided to each consumer. Grievance policy includes: 1. To whom complaints can be made 2. Steps necessary to file a grievance 3. Time lines and steps taken by the agency to resolve the grievance 4. Documentation by the agency of the process, including a standardized grievance form available in a language and format understandable to the consumer 5. An appeal process when services are terminated 6. All complaints or grievances initiated by consumers are documented on the agency's standardized form 7. Resolution of each grievance is documented on the Standardized form and shared with consumer 8. Confidentiality of grievance 9. Non-retaliation policy for consumers who file a grievance 10. Addresses and phone numbers of licensing authorities and funding sources	Policies and Procedure Signed receipt of agency Grievance Policy in consumer files
Cultural & Linguistic Competency	**Measure**
Agency demonstrates a commitment to provision of services that are culturally sensitive and language competent for people with Limited English Proficiency. Services adhere to National Standards on Culturally and Linguistically Appropriate Services (CLAS).	Procedures for obtaining translation services; Employment of bilingual staff and a diverse workforce reflective of PLWH in the TGA;

	Staff trained in cultural sensitivity; Agency's documents are translated in languages used by consumers
Agency visibly posts its non-discrimination policy where consumers have an opportunity to read it (i.e. waiting rooms)	Non-discrimination policy visibly posted in language(s) appropriate for Agency's consumers
Privacy & Confidentiality	**Measure**
Confidential information is acquired, used, disclosed, and stored only for legitimate purposes related to the service.	Policies and Procedures
Printed documents with confidential information is stored in a locked cabinet or secure lock box when not in use.	Policies and Procedures
Staff do not email confidential information unless it is encrypted.	Policies and Procedures
Staff have password protection on all electronic devices used to store / access confidential information, including phones, computers, laptops, tablets.	Policies and Procedures
Individuals (consumers, staff, volunteers, etc.) sign confidentiality agreements before receiving access to confidential health data and annually thereafter.	Policies and Procedures; Copy of signed agreements for all staff, volunteers, consumers, etc.
When sharing data across provider organizations, a Data Sharing Plan is completed and includes: 1. Intent of the activity 2. Persons authorized to access confidential information 3. Specific information to be released 4. Physical and electronic security protections 5. Time-limits for releases not exceeding 1 year 6. Printed name and signature of consumer or legal guardian 7. Signature of a witness	Policies and Procedures
If an agency accidentally shares a consumer's information, the agency notifies the consumer within 24 business hours.	Policies and Procedures
Record retention follows NC/SC policies regarding retention, storage, and disposition of files. Consumer files are retained for 7 years from date of case closure or from termination of contract with Mecklenburg County. Disposed consumer files are securely shredded.	Policies and procedures; Consumer files
Recertification Requirements	**Measure**
Agency conducts 6-month recertification of eligibility for all consumers. At a minimum, the agency confirms an individual's income and residency and obtains most recent CD4/Viral Load labs.	Documentation in consumer files
Agency ensures that Ryan White is the Payer of last resort and has Policies & Procedures addressing strategies to enroll all eligible uninsured consumers into Medicare, Medicaid, private health insurance, and other programs.	Policies and Procedures Documentation in consumer files

Early Intervention Services

Early intervention services (EIS) include counseling individuals with respect to HIV; referrals; other clinical and diagnostic services regarding HIV; periodic medical evaluations for individuals with HIV; and providing therapeutic measures. HIV education, including risk prevention and adherence counseling are a part of every patient encounter. EIS:

1. Assists clients with linkage to care and follow-up on participation in out-patient HIV medical care (primary focus) and
2. To address barriers to care, assist clients in linkage care to and follow up on participation in other Ryan White core medical and support services and non-Ryan White community services.
3. Develops formal relationships with "Points of Entry" and informal relationships with other community contacts who are engaged in the provision of HIV related services. Points of Entry are agencies/organizations that provide HIV testing and other related services.

Intake & Eligibility	**Measure**
EIS are specifically designed to be provided to PLWH who are: 1. Newly diagnosed, 2. Pregnant, 3. Being released from incarceration (up to 90 days before release), 4. In medical care and have identified issues that adversely impact retention in care, or 5. Not in care.	Documentation in consumer files of new diagnosis, pregnancy, history of incarceration, identified barriers to retention in care, or out of care status
If consumer is actively enrolled in Medical Case Management services, EIS may be abbreviated.	Documentation in consumer files
Key Services Components & Activities	**Measure**
According to RWHAP PCN 16-02, EIS includes these 4 components: 1. Targeted HIV testing to help the unaware learn of their HIV status and receive referral to HIV care & treatment services if found to be HIV+, 2. Referral services to improve HIV care and treatment services at key points of entry, 3. Access and linkage to HIV care and treatment services, and 4. Outreach Services and Health Education / Risk Reduction related to HIV.	Policies and Procedures
EIS activities mirror evidence-based models and best practices, such as CDC's Data to Care. See effectiveinterventions.cdc.gov	Policies and Procedures Progress notes in consumer files
EIS staff collaborate with state and local DIS to enhance access to care while avoiding duplication of services.	Documentation in consumer files MOUs/MOAs with DIS agencies
EIS staff demonstrate communication with HIV medical providers, other EIS agencies, points of entry, and medical case management agencies.	Memorandum of Agreement / Understanding with partner agencies
Services, service plans, reassessments, and reviews of the consumer's participation, successes, and barriers are documented.	Documentation in consumer files
Personnel Qualifications	**Measure**
EIS staff possess, at minimum, a high school diploma or GED.	Documentation in staff files
EIS staff are supervised by someone with a bachelor's degree and 5 years of experience or equivalent experience; master's degree preferred	Documentation in staff files
Assessment & Service Plan	**Measure**
EIS staff identifies specific barriers the consumer has / may experience in accessing medical care and remaining in care, including: 1. Medical history / physical health 2. Health resources, including health literacy 3. Psychosocial: Emotional, substance use, and mental health 4. Risk / harm reduction: Sexual practices and drug use 5. Housing 6. Financial resources	Documentation in consumer files (May include previous assessments from medical practice)

7. Social network: People and systems that are a resource 8. Practical resources: Transportation, child care, nutrition 9. Service needs and barriers	
Consumer and EIS staff collaboratively develop service plans, which include: 1. List of consumer-identified service needs 2. Establishment of specific, action-oriented, and achievable goals with a specific timeframe for completion (3-12 months) 3. Measurable objectives / action steps to accomplish goals 4. Resources to accomplish goals	Service plan signed and dated by consumer and staff in consumer files
Service plans are completed within 10 working days of intake.	Documentation in consumer files
Service plan provides evidence of on-going involvement and is reviewed quarterly.	Documentation in consumer files
Each consumer is reassessed every 6 months, or more often as needed. During reassessment, the consumer and EIS staff collaboratively reevaluate the service plan. The reassessment includes: 1. Updating/revising service plan 2. Appointment status and referrals 3. Special intervention activities 4. Special needs	Updated service plan signed and dated by consumer and staff in consumer files
Consumer Rights & Responsibilities: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality	**Measure**
EIS staff ensure that they conduct new activities with the least infringement on a consumer's autonomy and privacy.	Policies and Procedures
Recertification Requirements: See General Standards	

Emergency Financial Assistance

Emergency Financial Assistance provides limited one-time or short-term payments to assist a HRSA RWHAP client with an urgent need for essential items or services necessary to improve health outcomes, including:

- Utilities,
- Housing,
- Food (including groceries & food vouchers*),
- Transportation,
- Medication not covered by ADAP or AIDS Pharmaceutical Assistance, or
- Another HRSA RWHAP-allowable cost needed to improve health outcomes.

EFA must occur as a direct payment to an agency or through a voucher program*+. Direct cash payments to clients are not permitted. (HIV/AIDS Bureau Policy 16-02).
*Per Mecklenburg County's guidelines, the Ryan White Program and its subrecipients are may not purchase gift cards, including gift cards for food and gas.

+ More than one method of payment must be provided as an option, including but not limited to: check, card, cashier's check, money order, etc.

Intake & Eligibility	**Measure**
In addition to general eligibility requirements, EFA staff ensure that consumers have tried to access at least 2 other community resources before receiving EFA.	Documentation in consumer files that assistance was requested & denied from 2 other agencies; or documentation that no other agencies provide these services in consumer's county
Consumers who have long-term housing needs should be referred to HOPWA and/or other housing resources	Policies and Procedures; Documentation in consumer files
Agency will adhere to the cap-per-client identified in the agency's contract.	Documentation of paid amounts / receipts in consumer file
Key Services Components & Activities	**Measure**
EFA occurs as a direct payment to an agency. HRSA/HAB does not permit direct payments to consumers. Mecklenburg County does not permit purchase or distribution of gift cards.	Policies and Procedures; Documentation in consumer files
Personnel Qualifications	**Measure**
EFA staff have a high school diploma or GED and one year of experience working with PLWH or appropriate training.	Documentation in staff files
Transition & Discharge: See General Standards	
Case Closure Protocol: See General Standards	
Consumer Rights & Responsibilities: See General Standards	
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	

Health Insurance Premium and Cost Sharing Assistance (HIPCSA)

Health Insurance Premium and Cost Sharing Assistance provides financial assistance for eligible clients living with HIV to maintain continuity of health insurance or to receive medical and pharmacy benefits under a health care coverage program. For purposes of this service category, health insurance also includes standalone dental insurance. The service provision consists of the following:

- Paying health insurance premiums to provide comprehensive HIV Outpatient/Ambulatory Health Services, and pharmacy benefits that provide a full range of HIV medications for eligible clients; and/or
- Paying standalone dental insurance premiums to provide comprehensive oral health care services for eligible clients; and/or
- Paying cost sharing on behalf of the client (HIV/AIDS Bureau Policy 16-02).

Intake & Eligibility	**Measure**
Before providing HIPCSA, provider assesses the consumer's eligibility for Medicaid to ensure that Ryan White is the payer of last resort.	Documentation in consumer files
Key Services Components & Activities	**Measure**
In accordance with PCN 16-02 and PCN 18-01, Provider ensures that consumers obtain healthcare coverage that includes at least 1 US FDA approved medicine in each drug class of core antiretroviral medicines outlined in the US DHHS' Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient / ambulatory health services; and the cost of paying for the health care coverage (including all other sources of premium & cost sharing assistance) is cost-effective in the aggregate versus paying for the full cost for medications and other appropriate HIV outpatient/ambulatory health services.	Documentation in consumer files
Private health insurance plans must, at minimum, provide comprehensive primary health care services, deemed adequate by the state. See PCN 18-01 for more details regarding private health insurance plans.	Documentation in consumer files
RWHAP funds must not be used to pay for premiums or cost sharing assistance for private health plans that are paid for or reasonably expected to be paid for by Medicaid. However, RWHAP funds may be used to pay for any remaining premium and/or cost sharing amounts not covered by Medicaid.	Documentation in consumer files
Allowable Medicare costs include: 1. Medicare Part B premiums and/or cost sharing in conjunction with paying for Medicare Part D premiums or cost sharing 2. Medicare Part C premiums and/or cost sharing when the Medicare Part C plan includes prescription drug coverage; or in conjunction with paying for Medicare Part D premiums and cost sharing for plans that do not include prescription drug coverage 3. Medicare Part D premiums or cost sharing in conjunction with paying Medicare Part B or C premiums or cost sharing; when cost effective versus paying the full cost of medications.	Documentation in consumer files
Consumers receiving assistance for Qualified Health Plan premiums: 1. Designate Premium Tax Credit to be taken in advance during enrollment 2. Update income information at Healthcare.gov every 6 months, with 1 update during annual Marketplace open enrollment/renewal periods 3. Submit prior year tax information no later than May 31st: a. Federal Marketplace Form 1095-A b. IRS Forms 8962 and 1040 (excludes 1040EZ) c. Reconciliation of APTC credits or liabilities	Documentation in consumer files

Personnel Qualifications	Measure
Staff demonstrate knowledge of HIV and ARTs, and experience competently serving PLWH.	Work experience and relevant trainings documented in staff files
Transition & Discharge: See General Standards	
Case Closure Protocol: See General Standards	
Consumer Rights & Responsibilities: See General Standards	
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	
Recertification Requirements: See General Standards	

Medical Case Management, including Treatment Adherence Services

Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely, coordinated access to medically appropriate levels of health & support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges) (HIV/AIDS Bureau Policy 16-02).

Intake & Eligibility	**Measure**
In addition to general eligibility criteria, agencies use screening criteria before enrolling a consumer in MCM services. Such criteria include: 1. Newly diagnosed and/or new to ART 2. CD4 <200 and/or VL >100,000 3. Fluctuating viral loads and/or not virally suppressed 4. Excessive missed appointments and/ or missed dosages of ART 5. Mental health and/or substance use that hinders the consumer's ability to access and participate in medical treatment 6. Housing instability 7. Opportunistic infections 8. Comorbidity with other STDs and/or Hepatitis 9. Unmanaged chronic health problems 10. Positive screening for intimate partner violence 11. Clinician's referral	Review of agency's screening criteria for medical case management Documentation in consumer files
MCM begins the intake process within 3 business days of receiving referral.	Documentation in consumer files
MCM provides the following information to the consumer: 1. Agency information 2. Description of key activities, purpose, and goals of case management 3. U=U (Undetectable = Untransmittable) 4. As applicable, referrals to needed resources in the TGA	Documentation in consumer files

Comprehensive assessment begins at intake, is completed annually thereafter, and includes: 1. Eligibility 2. Demographic information 3. Health history, including sexual, mental, and substance use (if change occurs) 4. Treatment adherence 5. Psychosocial needs and strengths 6. Resources, including Financial and Health insurance status 7. Perceived limitations / barriers to service 8. Risk / harm reduction counseling	Documentation in consumer files
Key Services Components & Activities	**Measure**
MCM services include, at a minimum: 1. Screening of consumers to determine level of need for case management 2. Collaborative development and evaluation of service plan 3. Follow-up and reassessment at least every 6 months 4. Linkage to available medical and support services, including referrals 5. Treatment adherence counseling 6. Risk/harm reduction counseling	Documentation in consumer files
MCM documents the coordination and follow-up of referrals for services.	Documentation in consumer files
Active files reflect a face-to-face visit at least twice a year.	Documentation in consumer files
Identified consumer needs are addressed within 7 business days.	Documentation in consumer files
Consumers have access to a MCM during normal business hours.	Policies and Procedures
Consumers are notified in writing within 30 days of a change in MCM.	Documentation in consumer files
MCM maintains case notes on all activities with or on behalf of consumers.	Documentation in consumer files
MCM communicates with other service providers to improve consumer linkage to service, including transportation, language, timely appointment availability, and service schedules.	Documentation in consumer files
At least annually, MCM reviews with consumer: 1. How to file a grievance 2. How to cancel a medical appointment and the importance of canceling in advance when one knows they cannot keep an appointment	Documentation in consumer files
Personnel Qualifications	**Measure**
MCM has a bachelor's degree in social work, human services, public health, nursing, or another relevant field; an associate degree (in the fields above) and 2 years of experience; a professional license (i.e. LPN) and 2 years of experience; or equivalent experience (4 years)	Copy of diploma, licensure, or official transcripts; Written explanation for anyone who does not meet this criterion
MCM Supervisors have a bachelor's degree in social work, human services, public health, nursing, or another relevant field; At least 1 year of case management experience, including experience working with PLWH	Copy of diploma or official transcripts; Documentation of relevant credentials or certifications
In addition to training requirements in General Standards, MCMs and supervisors may receive training in one or more of the following topics: 1. ADAP/HMAP: How to access services 2. Health insurance enrollment 3. Case management skills building	Training certificates in staff files
Assessment & Service Plan	**Measure**
Service plans begin at admission to MCM services.	Documentation in consumer files
Consumer and MCM collaboratively develop service plans, which include: 1. List of consumer-identified service needs 2. Establishment of specific, action-oriented, and achievable goals with a specific timeframe for completion (3-12 months)	Service plan signed and dated by consumer and MCM

3. Measurable objectives / action steps to accomplish goals 4. Resources to accomplish goals	
Service plan is re-evaluated at least quarterly by MCM and consumer to document consumer's progress, successes, and solutions to barriers.	Updated service plans signed and dated by consumer and MCM
Transition & Discharge: See General Standards	
Case Closure Protocol	**Measure**
Upon termination or discharge, a final narrative is completed and approved by the supervisor before the case is considered closed.	Documentation in consumer files
Consumers Rights & Responsibilities	**Measure**
Consumers receive a copy of the Consumer Rights & Responsibilities Policy upon determination of eligibility. The policy: 1. Ensures that a consumer's decisions and needs drive the MCM process 2. Ensures a fair process of case review if the consumer feels they have been mistreated, poorly serviced, or wrongly declined/discharged from services 3. Clarifies the consumer's responsibility in facilitating communication and service delivery	Documentation in consumer files
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	
Recertification Requirements: See General Standards	

Medical Transportation

Medical Transportation is the provision of nonemergency transportation that enables an eligible client to access or be retained in core medical and support services (HIV/AIDS Bureau Policy 16-02).

Intake & Eligibility	**Measure**
The provider referring the consumer screens for **van services** eligibility. Consumers are eligible for van services if: 1. Consumer meets General Eligibility Standards, 2. Does not have Medicaid, 3. Is not eligible for ACCESS (Gaston), 4. Lives in a county with no bus line; or lives off the bus line and does not qualify for CATS Special Transportation Service (Mecklenburg), and 5. Is not eligible for other existing transportation services.	Policies and Procedures; Screening tools/process; Documentation in consumer files
The provider referring the consumer screens for **bus pass** eligibility. Consumers are eligible for bus passes if: 1. Consumer meets General Eligibility Standards, 2. Does not have Medicaid, and 3. Has access to the bus line.	Policies and Procedures; Screening tools/process; Documentation in consumer files
Provider makes appropriate referrals to other transportation resources if consumer does not meet eligibility criteria for medical transportation.	Policies and Procedures; Documentation in consumer files
Key Services Components & Activities (van services)	**Measure**
Vehicles have appropriate, updated registration and insurance.	Copy of registration and insurance
Vehicles have regular maintenance and inspections according to the vehicle's maintenance schedule.	Policies and Procedures; Documentation of maintenance
Vehicles have standard safety equipment in compliance with federal and state laws.	Policies and Procedures
Provider is compliant with the Americans with Disabilities Act, ensuring that services are available to those with disabilities requiring assistive devices.	Site visit; Maintenance of transport mechanisms documented
Provider offers door-to-door services to consumers with disabilities.	Policies and Procedures
Services are available for consumers outside of normal business hours.	Policies and Procedures
Personnel Qualifications (van services)	
Drivers have, at minimum, a valid chauffer's license. Provider verifies the driving records of drivers annually.	Copy of current Chauffeur's License; Annual records review documented
Picture identification of each driver is posted in the vehicle.	Documentation in vehicle
Agency performs criminal background checks on all direct service personnel before transporting consumers.	Documentation in staff files
Drivers have annual proof of safe driving record, including DWI/DUI and other traffic violations. Convictions of 3 or more moving violations in the past year or 1 DWI/DUI in the past 3 years disqualify the driver.	Documentation in staff files
Assessment & Service Plan	**Measure**
Transportation Provider ensures: 1. Follow-up verification between transportation provider and destination service program confirming use of eligible service(s), or 2. Consumer provides proof of service documenting use of eligible services at destination agency on the date of transportation, or 3. Scheduling of transportation services by receiving agency.	Documentation of confirmation from destiny agency in consumer record; or Consumer's original receipt from destination agency in consumer record; or Documentation in case manager's progress notes
Transition & Discharge: See General Standards	
Case Closure Protocol: See General Standards	

Consumer Rights & Responsibilities	Measure
Before receiving van services, consumers read and sign Transportation Consent.	Documentation in consumer files
It is the consumer's responsibility to notify referring provider of the need for medical transportation. Agencies and consumers should work collaboratively to decide what defines "timely" notification.	Documentation of consumer's request for medical transportation in consumer files
Consumers are immediately notified of problems (e.g. vehicle breakdown).	Documentation in consumer files
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality (van services)	**Measure**
Transportation vehicles are not marked with identifying labels indicative of HIV services (e.g. red ribbon, the words "HIV" or "AIDS").	Review of vehicle during site visit

Mental Health Services

Mental Health Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV. Services are based on a treatment plan, conducted in an outpatient group or individual session, and provided by a mental health professional licensed or authorized within the state to render such services. Such professionals typically include psychiatrists, psychologists, and licensed clinical social workers (HIV/AIDS Bureau Policy 16-02).

Intake & Eligibility	**Measure**
Provider completes an initial mental health assessment including: 1. Presenting problem(s) 2. Psychological history 3. Mental status examination 4. Differential diagnoses 5. Treatment recommendations	Documentation in consumer record signed and dated by licensed professional conducting the assessment
Key Services Components & Activities	**Measure**
Agency has provisions and mechanisms for urgent care evaluation and triage.	Policies and Procedures
Provider develops and maintains collaboration with primary care providers.	Documentation in consumer files
Personnel Qualifications	**Measure**
Staff delivering mental health services have valid certification/licensure as a mental health professional; or are license-eligible as required by the States of NC/SC.	Copy of most recent license and valid certification
Licensed staff satisfactorily complete all appropriate CEUs/CMEs based on individual licensure requirements. These trainings may overlap with training requirements in General Standards.	Certificates in staff files
A licensed mental health provider supervises license-eligible staff.	Certification/Licensure in staff files
Assessment & Service Plan	**Measure**
Files include a detailed service plan for each consumer, which includes: 1. Diagnosed mental illness or condition 2. Treatment modality (group or individual) 3. Start and end dates for services 4. Recommended number of sessions 5. Reassessment date 6. Follow-up plan	Documentation in consumer files signed and dated by professional rendering the service
Provider documents services provided, including modality, dates of service, and progress notes. Services align with consumer needs and service plans.	Documentation in consumer files
Transition & Discharge: See General Standards	
Case Closure Protocol: See General Standards	
Consumer Rights & Responsibilities: See General Standards	
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	

Oral Health Care

Oral Health Care activities include outpatient diagnosis, prevention, and therapy provided by dental health care professionals, including general dental practitioners, dental specialists, dental hygienists, and licensed dental assistants (HIV/AIDS Bureau Policy 16-02).

Intake & Eligibility	**Measure**
Agency documents health history before providing care, including: 1. Consumer's viral load and CD4 count 2. Consumer's chief complaint, where applicable 3. Medication names 4. Allergies and drug sensitivities 5. Alcohol, tobacco, and recreational drug use 6. Neurological diseases 7. Usual oral hygiene and date of last dental examination 8. Involuntary weight loss or gain	Documentation of relevant health history and allergies in consumer record
Key Services Components & Activities	**Measure**
Consumers receive at least 1-2 dental cleaning(s) every 12 months.	Documentation of last cleaning date in consumer files
Oral health shall meet the established minimum standards and ethical practices set forth by the American Dental Association.	Documentation of standards and ethical practices
Oral health care primarily focuses on alleviating discomfort, keeping teeth and gums healthy, preventing infection, and maintaining the ability to eat nutritional foods with the goal of optimizing overall health.	Documentation in consumer files; Treatment plan (when applicable)
Regular oral health appointment includes a thorough examination, charting of caries, x-rays, periodontal screening, and cleaning. Applicable follow-up services include education, preventative home care instructions, written diagnoses, and a treatment plan.	Documentation in consumer files; Treatment plan (when applicable)
Personnel Qualifications	**Measure**
Licensed staff receive training adequate to maintain licensure. This training may overlap with General Standards training requirements.	Training certificates in staff files
Providers have an appropriate license, credentials, and expertise as required by the States of North Carolina and South Carolina.	Documentation of licensures in staff files
Assessment & Service Plan	**Measure**
When a consumer requires care beyond a standard cleaning, the provider and consumer collaboratively develop a comprehensive treatment plan, including: 1. Reason for dental visit / further treatment 2. All related oral health issues and action steps to address each issue 3. A timeline for completion of each action step 4. Consumer strengths and limitations to completing the plan	Treatment plan signed and dated by the provider and consumer in consumer files, including updated plans
Treatment priority is given to pain management, infection, traumatic injury, or emergency conditions. Solely cosmetic treatments will not be reimbursed.	Documentation of presenting problems in consumer files
Transition & Discharge: See General Standards	
Case Closure Protocol: See General Standards	
Consumer Rights & Responsibilities	**Measure**
Before receiving Oral Health Care, consumers are made aware of what services/treatments Ryan White does and does not cover.	Documentation and consumer signature in consumer files
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	

Outpatient / Ambulatory Health Services

Outpatient/Ambulatory Health Services provide diagnostic and therapeutic-related activities directly to a client by a licensed healthcare provider in an outpatient medical setting. Outpatient medical settings may include: clinics, medical offices, mobile vans, using telehealth technology, and urgent care facilities for HIV-related visits. Allowable activities include:

- Medical history taking
- Physical examination
- Diagnostic testing (including HIV confirmatory and viral load testing), as well as laboratory testing
- Treatment and management of physical and behavioral health conditions
- Behavioral risk assessment, subsequent counseling, and referral
- Preventive care and screening
- Pediatric developmental assessment
- Prescription and management of medication therapy
- Treatment adherence
- Education and counseling on health and prevention issues
- Referral to and provision of specialty care related to HIV diagnosis, including audiology and ophthalmology

(HIV/AIDS Bureau Policy 16-02)

Intake & Eligibility	**Measure**
Newly diagnosed and/or returning to care clients should be seen within 2 business days of receipt of referral. This is a WHO and CDC recognized best practice to engage clients in care as soon as possible.	Documentation of referral, first patient contact, and first appointment date in consumer files
Consumers receive an initial comprehensive medical evaluation and physical examination completed by a MD, DNP, NP, CNS, or PA. A comprehensive reassessment is completed annually or when clinically indicated, and includes: 1. General medical history 2. Psychosocial history 3. HIV treatment history and staging 4. Most recent CD4 counts and VL test results 5. Resistance testing and co-receptor tropism assays as clinically indicated 6. Medication adherence history 7. History of HIV-related illness and infections 8. History of Tuberculosis 9. History of Hepatitis and vaccines 10. Psychiatric history 11. Transfusion / blood products history 12. Past medical care 13. Sexual history 14. Substance use history 15. Review of Systems	Completed assessment in consumer's record
Key Services Components & Activities	**Measure**
HIV primary care service tasks include: 1. Procedures for implementing legislation related to pregnant people 2. Reasons for visit clearly stated 3. Medical and psychosocial history in record 4. Current problem and medicine list 5. Written clinic procedures 6. Reproduction counseling (when applicable) 7. Nutritional counseling (when applicable) 8. Service plan in consumer record	Policies and Procedures; Documentation in consumer files

9. After-hour appointments available for consumers 10. Reasonable wait time for appointments 11. Consumers screened for HAB measures 12. At minimum, annual testing for STIs for all sexually active consumers, including oral, genital, and anal screenings 13. TB testing at least once for newly diagnosed consumers See https://aidsinfo.nih.gov/guidelines for more information.	
Consumers with cervixes have regular pap tests. 1. An initial pap test is followed with another pap test in 6-12 months, and if negative, annually thereafter. 2. If 3 consecutive pap tests are normal, follow-up pap tests are completed every 3 years 3. Consumers over age 29 may have a pap test and HPV co-testing, and if normal, repeated every 3 years 4. A pap test showing abnormal results is managed per guidelines	Documentation in consumer files
If clinically indicated, providers offer the following to consumers: 1. Screening for anal cancer 2. Chemical panel with LFT and renal function test 3. Pneumonia vaccine 4. Influenza vaccine during peak flu season 5. HPV vaccine 6. Hepatitis A and B vaccines (when not already immune) 7. Tobacco cessation counseling with resources provided	Documentation in consumer files
Licensed providers provide comprehensive, documented education regarding consumer's most current prescribed ART regimen, including: 1. Names, actions, and purposes of all medications in the regimen 2. Dosage schedule 3. Food requirements, if any 4. Side effects and drug interactions 5. Adherence 6. How to pick up medicines and get refills 7. What to do and who to call when having problems taking medications	Documentation in consumer files, including affirmation that consumer demonstrated understanding of topics discussed
Agency has a policy regarding consumer retention in care, addressing: 1. Process for consumer appointment reminders (e.g. timing, frequency, position responsible) 2. Process for contacting consumers after missed appointments (e.g. timing, frequency, position responsible) 3. Measures to promote retention in care 4. Process for reengaging those out of care in last 6 months	Policies and Procedures
In accordance with US DHHS recommendations, preconception care and counseling are a component of routine primary care for people with uteruses of child bearing age. In addition to the general components of preconception counseling, providers, at a minimum: 1. Assess consumers pregnancy intentions on an ongoing basis and discuss reproductive options 2. Offer effective and appropriate contraceptive methods to people who wish to prevent pregnancy 3. Counsel on safer sexual practices 4. Counsel on eliminating alcohol, illicit drugs, and tobacco 5. Educate and counsel on risk factors for perinatal HIV transmission, strategies to reduce those risks, prevention, and potential effects of HIV and treatment on pregnancy course and outcomes	Documentation in consumer files

6. Interventions to prevent HIV transmission to an HIV-negative partner Other preconception care considerations include: 1. The choice of appropriate ART effective in treating maternal disease with no teratogenicity or toxicity should pregnancy occur 2. Maximum viral load suppression prior to conception http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf	
Obstetrical care for pregnant consumers is provided by board-certified obstetricians experienced in the management of high risk pregnancy and who has at least 2 years of experience caring for pregnant PLWH. ART during ante partum, perinatal, and postpartum is based on current HHS guidelines.	Documentation in consumer files
Personnel Qualifications	**Measure**
Medical care for PLWH is provided by MD, DNP, NP, CNS, or PA currently licensed in the State of NC / SC.	Copy of current license
Contracted services providers have current license and/or certification within their professional scope of practice and as required by the State of NC or SC.	Copy of current licenses / certifications in staff files
All staff maintain current organizational licensure / certification and professional licensure.	Documentation in staff files
Supervising/ attending physicians show professional development in accordance with HRSA recommendations for HIV-qualified physicians: 1. Providers and contractors maintain a minimum of 30 hours of HIV-specific CME per year, including minimum 10 hours related to ART 2. Physician extenders obtain this experience within 6 months of hire 3. All staff receive professional supervision This training may overlap with General Standards training requirements.	Documentation of training certificates in staff files
Assessment & Service Plan	**Measure**
A service plan is developed for each identified problem and addresses diagnostic, therapeutic, and educational issues in accordance with the current US HHS treatment guidelines.	Service plan in consumer files
Consumers have follow-up visits every 3 to 6 months, or as clinically indicated, for treatment monitoring and to detect any changes in HIV status. At each clinic visit, the provider, at minimum: 1. Measures vital signs, including height and weight 2. Performs physical examination and updates consumer history 3. Measures CBC, CD4, and VL levels 4. Evaluates need for ART 5. Provides resistance testing, if clinically indicated 6. Evaluates need for prophylaxis of opportunistic infections 7. Documents current therapies on consumers receiving treatment; assesses and reinforces adherence with the service plan 8. Updates problem list 9. Refers consumer for ophthalmic examination by an ophthalmologist every 6 months when CD4 count falls below 50 CU/MM 10. Refers consumer for dental cleaning / screening every 12 months 11. Screens risk behaviors and provides risk reduction education, including PrEP (pre-exposure prophylaxis), nPEP (non-occupational post-exposure prophylaxis), and Undetectable = Untransmittable (U=U) 12. Assesses consumer comprehension of service plan 13. Refers for other medical and support services where indicated	Content of follow-up documented in consumer files; Documentation of specialist referrals, including vision and dental in consumer files

Agency has a written policy regarding consumer mental health and substance use, addressing: 1. Agency's process for assessing consumer mental health / substance use 2. Treatment and referral of consumers for mental health / substance use 3. Care coordination with mental health / substance use providers 4. Guidelines for addressing suicidal and/or homicidal consumers, including (a) safety plan guidance and (b) process for involuntary admission	Policies and Procedures with appended Safety Plan template
Agency has a written policy regarding consumer Intimate Partner Violence (IPV) Screening, addressing: 1. Process for ensuring consumers are screened for IPV at least annually 2. Intervention procedures for consumers who screen positive for IPV 3. State reporting requirements associated with IPV (if any) 4. Description of required medical record documentation 5. Procedures for consumer referral to resources 6. Plan for training all appropriate staff	Policies and Procedures; Documentation in consumer files
Transition & Discharge	**Measure**
Consumer is notified of primary care provider's cessation of employment within 30 days of the employee's departure.	Documentation in consumer files
Case Closure Protocol: See General Standards	
Consumer Rights & Responsibilities: See General Standards	
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	
Recertification Requirements: See General Standards	

Vision Services

Vision Services are an integral part of Outpatient / Ambulatory Health Services. Vision services consist of comprehensive examination by a qualified Optometrist or Ophthalmologist. Allowable visits with a credentialed Ophthalmic Medical Assistant include routine and preliminary tests such as muscle balance test, Ishihara color test, Near Point of Conversion (NPC), visual acuity testing, visual field testing, Lensometry and glasses dispensing.

Intake & Eligibility	**Measure**
Agency collects the following information for all new consumers: 1. Health history 2. Ocular history 3. Current medications 4. Allergies and drug sensitivities 5. Reason for visit (chief complaint) 6. When clinically indicated, current (within last 6 months) CD4 and Viral Load test results	Documentation in consumer files
Key Services Components & Activities	**Measure**
A comprehensive eye exam includes the following: 1. Visual acuity 2. Refraction test 3. Binocular vision muscle assessment 4. Observation of external structures 5. Fundus / retina exam 6. Dilated fundus exam, when clinically indicated 7. Glaucoma test 8. Written diagnoses and Treatment plan, where applicable	Documentation in consumer files of all tests, findings, written diagnoses, and treatment plans
Consumers who have clinical indications for corrective lenses receive prescriptions and referrals for such services to ensure they can obtain their prescribed corrective lenses.	Documentation in consumer files, including any referrals made
Personnel Qualifications	**Measure**
Licensed staff receive training adequate to maintain licensure. This training may overlap with General Standards training requirements.	Training certificates in staff files
Provider has a staff Doctor of Optometry licensed by the State of NC or SC respectively, or a medical doctor who is board certified in ophthalmology.	Documentation of work experience and licensure in staff files
Supervision of clinical staff is provided by a practitioner with at least 2 years of experience in vision care and treatment of PLWH.	Policies and Procedures; Documentation in staff files
Transition & Discharge: See General Standards	
Case Closure Protocol: See General Standards	
Consumer Rights & Responsibilities: See General Standards	
Grievance Process: See General Standards	
Cultural & Linguistic Competency: See General Standards	
Privacy & Confidentiality: See General Standards	

Psychosocial Support Services

Psychosocial Support Services provide group or individual support and counseling services to assist HRSA RWHAP-eligible PLWH to address behavioral and physical health concerns. Activities may include:

- Bereavement counseling
- Child abuse and neglect counseling
- HIV support groups
- Nutrition counseling provided by a non-registered dietitian
- Pastoral care/counseling services

(HIV/AIDS Bureau Policy 16-02)

Intake & Eligibility: See General Standards	
Key Services Components & Activities	**Measure**
Provider documents services provided to individuals and groups. Progress notes include: 1. Type of service (group or individual) 2. Frequency of service 3. Clear justification for support	Sign-in sheets at support groups; List of group session topics; Documentation in consumer files of individual counseling, if applicable
Providers and consumers collaboratively choose topics, evaluate services, and select meeting times/locations.	Consumer surveys / focus group notes
Personnel Qualifications	**Measure**
Provider is qualified to treat consumers (experienced in peer mentorship, pastoral counseling, or other relevant experience).	Documentation of experience providing services in staff files
Provider documents supervision of non-licensed paraprofessional counselor/ mentor.	Staff files
Assessment & Service Plan	**Measure**
Consumer and staff collaboratively develop service plans, which include: 1. List of consumer-identified service needs 2. Establishment of specific, action-oriented, and achievable goals with a specific timeframe for completion (3-12 months) 3. Measurable objectives / action steps to accomplish goals 4. Resources to accomplish goals	Service plan signed and dated by consumer and staff
Service plan is re-evaluated at least quarterly by staff and consumer to document consumer's progress, successes, and solutions to barriers.	Updated service plans signed and dated by consumer and staff
Transition & Discharge	
See General Standards	
Case Closure Protocol	
See General Standards	
Consumer Rights & Responsibilities	**Measure**
HRSA RWHAP-funded pastoral counseling is available to all eligible consumers regardless of their religious affiliation.	Policies and Procedures
Grievance Process	
See General Standards	
Cultural & Linguistic Competency	
See General Standards	
Privacy & Confidentiality	
See General Standards	

Appendix A: Performance Measures

Service Category	Measure	Numerator	Denominator	Relevant Data Elements
OAMC MCM	HIV VIRAL LOAD SUPPRESSION: 1. Percentage of patients, regardless of age, with a diagnosis of HIV with a viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year	Last Quantitative Lab Value HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed
OAMC	PRESCRIPTION OF HIV ART 2. Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year	Number of patients from the denominator prescribed HIV antiretroviral therapy during the measurement year	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year	# of ARV active ingredients HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed
OAMC MCM HIPCSA MH MT PSS EIS	HIV MEDICAL VISIT FREQUENCY 3. Percentage of clients, regardless of age, with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits	Number of patients in the denominator who had at least one medical visit in each 6- month period of the 24- month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the first 6 months of the 24 month measurement period *EXCLUDES clients that died during measurement year	HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed Vital Status
OAMC EIS	GAP IN HIV MEDICAL VISITS 4. Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.	Number of patients in the denominator who did not have a medical visit in the last 6 months of the measurement year	Number of patients, regardless of age, with a diagnosis of HIV who had at least one medical visit in the first 6 months of the measurement year *EXCLUDES clients that died during measurement year	HIV Positive Any Outpatient/Ambulatory Visit -OR- MCM HIV Specialist Confirmed -OR- EIS Linkage to Medical Care Confirmed Vital Status

Appendix B: Unit Definitions

Health Insurance Premium & Cost Sharing Assistance (HIPCSA)

Unit Definition: 1 unit = per co-pay deductible / premium

Subcategories:

Health insurance co-payments: the activity of paying insurance co-payment

Health insurance deductible: the activity of paying insurance deductible

Medical Case Management (MCM)

Unit Definition: 1 unit = 15 minutes of service provided

Subcategories:

MCM Intake: activities related to initial rapport building, completing intake form, consents, and releases; gathering URS and eligibility information

MCM Assessment: activities related to completing biopsychosocial assessment, acuity scale, consents and releases

MCM Care Plan Review: activities related to completing the service plan at assessment or reassessment

MCM Face-to Face: activities that do not easily fit into other categories listed here: listening to client, providing support, advocating on client's behalf

MCM Telephone: activities that do not easily fit into other categories listed here (see above)

MCM Reassessment: activities related to updating client's biopsychosocial areas and acuity scale, updating URS and eligibility information, updating consents and releases

MCM Telephone to Provider: activities related to supervision, case conference, contact with client's providers related to coordinating client's service

MCM Client Home Visit: activities related to MCM travelling to a client's home for evaluation

Medical Transportation

Unit Definition: 1 unit = 1-way trip or 1 bus pass

Subcategories:

Bus Pass: the activity of providing a bus pass to a client

Bus Pass Monthly: the activity of providing a monthly bus pass to a client

Private Service: the activity to provide door-to-door transportation to clients that cannot access public transportation

Mental Health

Unit Definition: 1 unit = 1 hour of service

Subcategory: **MH Licensed Counselor**: activities related to providing one individual session by a licensed counselor

Oral Health Care

Unit Definition: 1 unit = per procedure

Subcategory: **Dental Care**: activities related to diagnostic, preventive, and therapeutic dental care

Outpatient / Ambulatory Health Services (OAHS)

Unit Definition: 1 unit = 1 occurrence of the specified activity or 1 occurrence of payment made

Subcategories:

Follow-up: activities related to the evaluation and management of an established patient

Labs: activities related to the performance of labs as ordered by the physician.

Primary Care: activities related to the evaluation and management of a patient by a primary physician

Specialty Care: activities related to the evaluation and management of a patient by a specialist

Nurse Visit: activities related to services provided by a nurse including medication adherence issues

Psychosocial Support Services

Unit Definition: 1 unit = 1 session

Subcategories:

Non-Licensed/Group Support: the activity of providing psychosocial group support

Non-Licensed/Individual Support: the activity of providing psychosocial individual support